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(54) A SYSTEM FOR ENHANCED IN-VIVO CLEARANCE OF DIAGNOSTIC AND/OR THERAPEUTIC AGENTS BY EXTRACORPOREAL DEPLETION OF AGENTS

SYSTEM ZUR VERBESSERTEN IN-VIVO AUSSONDERUNG DIAGNOSTISCHER UND/ODER THERAPEUTISCHER WIRKSTOFFE DURCH EXTRAKORPORALES ENTFERNEN DER WIRKSTOFFE

DISPOSITIF DE ELIMINATION IN-VIVO AMELIOREE D'AGENTS DIAGNOSTIQUES ET/OU THERAPEUTIQUES PAR ENLEVEMENT EXTRACORPOREL DES AGENTS

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Description

[0001] The present invention relates to a method and a system for reducing non-target levels of specific molecules intended for diagnostic and/or therapeutic applications vertebrate hosts. In particular, it relates to methods, compositions and means for the extracorporeal removal from the blood circulation of exogenous targeting molecules prelabelled with a specific affinity ligand which can bind with high affinity to a corresponding receptor immobilized to an extracorporeal device.

[0002] The invention is applicable to the removal of any type of exogenous targeting molecule from the blood circulation, provided that these agents are targeted to a specific type of tissue, a specific type of cell or a specific type of extracellular or intra-cellular marker, and provided that this targeting molecule can be labelled with an affinity ligand without severely effecting the intrinsic affinity and specificity of the targeting molecule. A second requirement is the availability of a receptor to which the affinity ligand has a high affinity, and which in its immobilized form could be used to eliminate the targeting molecule from the blood circulation without affecting endogenous blood components or other exogenous administered components.

Antibodies have been found useful as targeting vehicles for diagnostic and therapeutic agents, inter alia radioisotopes, magnetic resonance imaging agents, enzymes toxins and cytotoxic drugs or prodrugs. These have been used especially in diagnosis or treatment, of cancer. Commonly, antibodies conjugated to diagnostic or therapeutic agents have been administered systemically, but other modes of administration have also been used.

[0003] In general, present immunotherapeutic strategies involve the administration of exogenous (non-human) antibodies to the patient. These antibodies are intended to interact only with a specific sub-set of cells while leaving the other cells unaffected. The antibodies are usually conjugated to a letal agent such as cytotoxic drugs or radioactive isotopes. In these cases, the therapeutic principle will be based entirely on the effect of the exogenously added therapeutic agent. Antibodies can also alone trigger a cytotoxic effect on cells exposing antigens to which the antibodies bind specifically. This is likely to be caused by two different but immunologically related mechanisms. One of these mechanisms, the antibody-dependent cell-mediated cytotoxicity (ADCC), acts through activation of cytotoxic lymphocytes. In the second case, cell lysis is dependent on complement activation which is triggered by antibodies bound to the specific cells. The conceptual simplicity of localizing tumours with radiolabelled antibodies in conjunction with external imaging has led to a great deal of research activities over the past years. Although techniques have improved, the clinical results are still hampered by some major limitations. Several of these limitations are due to parameters which are patient-dependent and can clearly not be altered.

The most important single determinant of detection sensitivity is, nevertheless, the uptake ratio of the localizing antibody on the tumour compared with the same antibody on surrounding normal tissues. Consequently, most work has centered on attempts to improve this uptake ratio with, as yet, limited success. Earlier work in this field has been based on polyclonal antibodies. The development of monoclonal antibodies would seem to have created ideal probes for these attempts. Monoclonal antibodies can be raised to tumour-selective antigens and because of the extremely high specificity there would be very little cross-reactivity with other cell markers, and consequently no, or very little, interaction with cells lacking these markers. However, human studies using mostly mouse monoclonal antibodies have, by and large, been disappointing in that respect. The extreme specificity of monoclonal antibodies, particularly if these antibodies recognize only one epitope per antigen might in some cases lead to a disadvantage in so far that a too small quantity of antibodies will be bound to the target cells, particularly if the number of accessible antigens is small. Mouse monoclonal antibodies, might also in spite of their intrinsic specificity, produce falsely positive localization due to their interaction with human Fc receptors on non-target cells. To overcome these problems, attempts have been made to use immunological fragments derived from monoclonal antibodies. Apart from the fact that these fragments most often lack the ability to interact with cells by non-idiotypic binding,they should also gain access to the target cells more readily than the intact molecule. Smaller molecules like Fab and $F(ab)_2$ fragments do indeed penetrate more rapidly into the tumour (Matzku et al. Int.J.Cancer Suppl. 2, 1988 11).However, the driving force causing a favourable diffusion of labelled antibodies into tumours is mainly dependent on the concentration gradient (Weinstein et al., Ann. N.Y. Acad.Sci., 1988, 199). Consequently, the blood concentration over time might be more important than the molecular size. Although the uptake of antibody fragment into the tumour might be higher, there is also likely to be a faster secretion of the antibody moieties into the urine. This is supported by data showing that the tumour concentration of antibodies was higher using intact antibody than using the corresponding antibody fragments (Wilbanks et al., Cancer 48, 1981, 1768).

[0004] Another approach has been the subtraction of background activity by simultaneous injection of non-target specific antibodies, carrying a second isotope. The latter should mimic the non-specific distribution of the tumour-directed antibody but emits a different photon energy. The two images are then subtracted. Although, this technique should in theory improve the contrast, there are, however , several practical problems. According to Bradwell et al. (Immunology Today 6, 1985, 163) artefacts may result from differences in energy between the two isotopes leading to positioning variability and different tissue attenuation of the gamma rays. Secondly, if the in vivo characteristics of the two isotopes are dissimilar, there will be a differential organ accumulation of the two detached isotopes. For example, the bladder always

contains an excess of free iodine or technetium which leads to hot or cold areas. Inequalities may also occur around the heart or stomach. Thirdly,the process of subtraction, whilst improving contrast, introduces additional statistic fluctuations without increasing the signal. A further disadvantage of this method is that the enhancement of contrast is achieved at the expense of introducing additional radioactive material into the body.

[0005] Methods have also been described to enhance the clearance of residual circulating antibodies from the blood circulation. It has been suggested that this could be achieved either by the administration of a second antibody or by modification of the carbohydrate part of the antibody or the antibody conjugate to enhance clearance by hepatic cells. In the former approach, a second antibody which specifically binds to the primary imaging antibody is administered. The second antibody is injected into the patient after sufficient time has elapsed following injection of the primary antibody.The time differece should permit maximum selective uptake of the primary antibody in the tumour to be imaged or treated therapeutically. The second antibodies will form aggregates with unbound imaging antibodies and these aggregates will then be cleared from the blood circulation of the patient through the body's own reticuloendothelial system. There are, however, conflicting views among experts in the field whether this is a feasible method or not (A.Klausner Biotechnology, 5, 1987,533). Such a method would for example mask several vital organs like spleen, lung, kidney and liver, since these are the organs mainly resposible for the uptake and clearace of the artificially induced immune complexes, referred to as aggregates.It should be noted that even if the primary tumour is not associated with the liver, this organ is nevertheless highly subseptible to metastasis. One also has to consider the risk of fluid phase complement activation caused by a relatively large amount of circulating immune complexes, which could theoretically lead to passive serum sickness. From a therapeutic point of view, one has to worry about the possible damage the conjugated toxins or radio-isotope might do to the cells of the spleen and other organs taking care of the "toxic waste". It is likely that these cells over a limited period of time will be exposed to irradiation or toxins of a magnitude close to the maximal tolerable dose of these sensitive organs. Alternative avenues to manipulate the blood clearance rate have recently been presented by M.J. Mattes, J.Natl.Cancer Inst. 79, 1987,855. Contrary, to the method of secondary antibody this method of blood clearance utilizes the hepatocytes rather than the reticulo-endothelial system. According to the latter method enhanced blood clearance can be induced either by better exposing glycoside residues normally associated with the antibodies or by introducing such residues on the antibodies or antibody conjugates through synthetic means. Some of these glycosides will bind tightly to lectin residues exposed on normal hepatic cells, and provided the number of such residues are sufficiently high, the antibodies or antibody conjugates will be accumulated in the liver and thereby cleared from the blood circulation. Radiolocalization studies have shown that target/non-target radioactivity ratios may be significally improved by introducing a two stage system in which radiolabelled avidin is administered following the injection of a biotinylated antibody (Paganelli,G. et al., Int.J.Cancer.Suppl. 2, 1988, 121; Oehr,P. et al. J.Nuclear.Med. 29, 1988, 728), or, alternatively, if radiolabelled biotin is injected following the administration of avidin-antibody conjugates (Hnatowich,D.D. et al. J.Nuclear Med 28, 1987, 1294). In general, these methods would suffer from drawbacks similar to those of the second antibody approach. The liver will be the recipient of the toxic waste and this vital organ will be masked for imaging.Futhermore, it should be difficult to use this method successfully if an antibody accumulation in the target site is orders of magnitude slower than accumulation in the liver. This method would also require a great deal of enzymatic or organic synthetic manipulation on the active component i.e. the antibody conjugate.

[0006] Specific removal of antibodies from the blood circulation by extracorporeal means is commonly applied in the therapy of immune-related disorders. The first attempt to remove endogenous antibodies from blood by employing hemoperfusion through a porous gel was described by Schenkein et al. in 1971 (Schenkein et al. J.Clin.Invest. 50, 1971, 1864). Somewhat later, Terman and co-workers (Lancet 2, 1979, 824) presented a technique in which a patient suffering from systemic lupus erythematosus was successfully treated by passing the patients plasma through a collodion-charcoal device. Extracorporeal techniques have also been used to overcome blood-group incompatibility. Blood treatment systems for the removal of anti-A and anti-B antibodies utilizing a technique in which synthetic blood-group antigens are covalently linked to a matrix have been described (Bensinger et al. N.Engl.J.Med.304, 1981, 160). Protein A covalently linked to a sepharose matrix has been used with the purpose to remove immunoglobulins from the blood-circulation in patients suffering from autoimmune diseases or from hyperimmunized patients. The principle out-line of such a system has been presented (Larsson, L.Å. et al, In Progress in artificial organs; Nosey, Kjellstrand, Ivanovich, eds., Cleveland,ISAO Press 1985, p902). Systems based on this principle have been used to reduce the level of anti-HLA antibodies prior to kidney transplantation of hyperimmunized patients (Palmer,A. et al., Lancet i, 1989, 10), and to remove anti-FVIII or anti-FIX antibodies to enable a successful treatment of heamophilia patients with factor extracts (Nilsson,I.M. et al., Blood 52, 1981, 38).

[0007] A system for the extracorporeal adsorption of immunoglobulins and circulating immune complexes utilizing columns where protein A has been covalently linked to a silica matrix is descibed in U.S. Patent No. 4,681,870.The extracorporeal removal of endogenous antibodies produced in response to treatment with exogenous antibody have been presented in the European Patent Application No.0 313 378. Removal of specific antibodies from whole blood in a continuous extracorporeal system has also been described (Nilsson, I.M.,et al., Plasma Ther.Transfus.Technol. 5, 1984, 127).

[0008] US Patent No. 5,474,772 (WO 91/01749) of Cobe Laboratories published after the priority date of the present application describes a method of therapeutic or diagnostic treatment using a medical agent in which there will be beneficial effects if the level of circulating medical agents is reduced artificially. The method includes the extracorporeal removal of medical agents by passing body fluid, but not whole blood, from the patient over a support adapted to selectively immobilise the medical agent.

[0009] WO 88/06045 of Schmoll et al describes a device for the removal of active substances locally applied against solid tumours. Toxic levels of agents are administered locally to solid tumours, and these toxins are prevented from entering the general circulation in the body. The device is a unit specific to a particular type of anti-cancer agent, each agent requiring its own specific decontaminating device.

[0010] WO 90/07929 of Bredehorst et al describes a method for site-specific in vivo activation of a prodrug in an animal using an activator-targeting moiety conjugate to localise an activator at a predetermined site of use and a prodrug compound that is converted to an active drug in the presence of the activator.

[0011] This invention concerns in its broadest aspect a kit as defined in claim 1.

A diagnostic concept.

[0012] This innovation can be utilized for diagnostic purposes in different ways. It can, for instance, be used with immunoscintigraphy for detection/localization of residule tumour growth and the presence of metastases. Another principle application is named immuno-guided surgery, where it can be used to better locate and define the border-line between tumour and normal tissues at the surgical procedure.

[0013] In the following general description of the techniques, the tumour targeting molecule is examplified by monoclonal antibodies and the extracorporeal adsorbent by avidin-columns.

[0014] The technology is based on increased uptake of radioactivity in tumour tissue compared to normal tissues. The radioactivity is selectively targeted to the tumour by using molecules specific for tumour antigens e.g.monoclonal antibodies. The distribution of radioactivity in the body is imaged by a scintillation camera.

[0015] The procedure involves the following steps:

Administration of radiolabelled immunoconjugate:

[0016] Tumour-selective monoclonal antibodies, labelled with a gamma-emitting radionuclide and conjugated with biotin, are injected into the patient. The immunoconjugate will distribute throughout the body and selectively target to areas with tumour growth.

Depletion of circulating immunoconjugate:

[0017] After a certain time, normally one to two days after the injection of the immunoconjugate, the uptake in the tumour has usually reached a maximum. However, only a small portion of the injected activity is localized to the tumour and most of the immunoconjugate is distributed in the circulation and the normal tissues. This excess of immunoconjugate increases the background and should be removed in order to improve the immunoscintigraphy. The depletion is performed by extracorporeal immunoadsorption of plasma through an avidin-column. Blood is drawn from the patient and continuously passed through a plasma separation device i.e. a plasma filter or an on-line centrifuge, the plasma is then passed through an avidin-adsorbent and the depleted plasma is mixed with the blood and returned to the patient. By this procedure about 90-95 % of the immunoconjugate,i.e. the targeting molecule carring the affinity ligand, is removed from the blood circulation after processing of about three times the plasma volume. The invention includes, however, also the possibility that the immunoconjugate is removed directly from whole blood.

Detection of radioactivity:

Immunoscintigraphy.

[0018] After termination of the extracorporeal treatment, the patient is placed in front of a scintillation camera and the distribution of radioactivity in the body is imaging with either planar or tomografic techniques. The tumour-to-background ratio in the images is improved. The immunoscintigraphic analysis may be repeated on day one or two.

Immuno-guided surgery.

[0019] Following termination of the extracorporeal procedure, the patient is ready for surgery. During surgery,the border-line between tumour and normal tissues is defined by the use of a hand-operated radioactivity detection probe.

A therapeutic concept.

[0020] The basis for this therapy is that tumour-selective agents e.g. monoclonal antibodies is used for selective targeting of tumour killing or tumour retarding substances to the tumour. The anti tumour agent might incorporate radionuclides, toxins, cytostatics, enzymes that activate prodrugs, or other suitable drugs linked to the antibodies. However, many of these agents might at higher concentration have cytotoxic or cystostatic effects on normal cells resulting in undesirable side effects in the patient. Even in the case of a highly tumour-selective targeting molecule (e.g. monoclonal antibody), only a small portion of the substance will be localized to the tumours. The remaining will be present in the blood circulation and in normal tissues. The innovation described in this patent application can be utilized for elimination of the circulating toxic substances from the blood, resulting in decreased side effects on normal tissues. The immunoconjugates to be used in connection with this innovation consist of three principal parts; a tumour-targeting module (e.g. a monoclonal antibody), an anti-tumour module (e.g. radionuclides, drugs etc), and an affinity ligand (e.g. biotin). The conjugate can be removed by utilizing the biospecific interaction with the affinty ligand (e.g. an avidin-adsorbent). Two or all three said functions may, however, be provided by one and the same molecule.

[0021] The procedure involves the following steps:

Administration of therapeutic immunoconjugate:

[0022] Tumour-selective monoclonal antibodies, conjugated with an anti-tumour agent, and labelled with preferably biotin, are administrated to the patient. The immunoconjugate will distribute throughout the body and selectively target to areas with tumour growth.

Depletion of circulating immunoconjugate:

[0023] After a certain time, normally one to two days after the injection of the immunoconjugate, the uptake in the tumour has reached a maximum. However, only a small portion of the injected dose is localized to the tumour and most of the immunoconjugate is distributed in the circulation and normal tissues. This excess of immunoconjugate increases the risk of side effects and have to be removed in order to improve the therapy. The depletion is performed by extracorporeal immunoadsorption of plasma, preferably by utilizing an avidin-column. Blood is drawn from the patient and continuously passed through a plasma separation device i.e plasma filter or on-line centrifuge. The plasma is then passed through an avidin-adsorbent and the depleted plasma is mixed with the blood and returned to the patient. By this procedure about 90-95 % of the immunoconjugate, present in the blood, is removed after processing of about three times the plasma volume. The invention includes, however, also the possibility that the immunoconjugate is removed directly from whole blood.

[0024] The injection of immunoconjugate and the subsequent removal of the excess of this toxic conjugate from the circulation may have to be repeated dependent on the nature of the neoplastic disease.

Embodiments:

[0025] The method of the present invention relies on the specific removal of previously administered synthetically modified target-specific agents from the blood-circulation in a host to be treated. Removal of these targeting molecules are achieved by the use of a specific adsorbent device having immobilized receptors specific to the affinity ligand. The latter may be covalently bound to the original targeting molecule. Such targeting molecules may constitute proteins carbohydrates or polynucleotides or may contain parts of these structural elements. Amomg proteins are the antibodies which could be of different isotypes and could originate from any species. Of particular interest are the monoclonal antibodies and derivatives thereof. The latter include enzymatically produced fragments such as the $F(ab')_2$, F(ab'), F(ab) and the like. They also include genetically engineered hybrids or chemically synthesized peptides based on the specificity of the antigen binding region of one or several target specific monoclonal antibodies e.g. chimeric antibodies, single chain antibodies etc.

[0026] The present invention may rely on the ability of covalent attachment of a specific affinity ligand onto the targeting molecule in a manner that does not severely affect the affinity and/or specificity of the targeting molecule in its interaction with the desired target cell. The affinity ligand may be any molecule which can be covalently attached to the targeting molecule.For therapeutic purposes the affinity ligand and the cytotoxic agent may constitute one single molecule to be attached to the targeting macromolecule. Cytotoxic agents,such as radionuclides , drugs or prodrugs may also be introduced directly on to the affinity ligand before or after attaching the affinity ligand to the targeting molecule.The affinity ligand may also be a prodrug. Furthermore, the affinity ligand may in addition also serve as an activator of prodrugs. In that case, the activator(e.g. an enzyme) being linked to the targeting molecule, may convert a prodrug to an active drug or toxin on(or close to) the target site (Senter, P.D. FASEB J. 4,188,1990). For the application of in

vivo diagnosis, the targeting molecule should carry an imaging agent, such as a radioisotope or a magnetic resonance imaging agent. These could be introduced directly onto the targeting molecule or the affinity ligand or the conjugate of the two. Although the affinity ligand may vary, biotin or derivatives thereof, e.g. 2-iminobiotin, desthiobiotin, diaminobiotin,would fulfill most of the requirements for this application. Biotin has an exceptionally high affinity for its receptor i.e. avidin or streptavidin. Biotin is easily coupled to antibodies often without loss of binding capacity. The biotin-avidin complex has a very small dissociation rate constant leading to an extremely long half life of the complex.

[0027] Biotinylation of proteins such as immunoglobulins can be achieved through various means. The amino groups in proteins can easily be conjugated by the use of biotinyl-p-nitrophenyl esters or biotinyl-N-succinimide esters. The coupling can also be achieved by direct coupling with carbodiimide, particularly watersoluble derivatives of the latter. In some cases it may be an advantage to use spacers of various length like caproylamidobiotinyl esters. Alternative ways of preparing biotin derivatives active with groups other than amino groups are also commonly used. Among these are biotinyl hydrazide which reacts with sugar and nucleic acid residues and biotinyl-bromoacetyl hydrazide or biotin maleimide which reacts with sulfhydryls and other strong nucleophiles. Biotinyl-diazoanilide can be used to conjugate biotin to phenol or imidazole functions. There are also other means by which the carboxyl group of the valeric acid side chain can be activated or converted to a reactive function.

[0028] The receptor to which the affinity ligand has a high affinity may be immobilized to various types of solid supports. The coupling method of choice will depend on the nature of the receptor as well as the nature of the immunosorbent support matrix. For protein based receptors, functional groups such as hydoxyl- amino- carboxyl- or thiol-groups may be utilized. Glycoproteins may be coupled to the matrix via their glycoresidues. The solid support may also be activated to enable binding of the receptor by means in which the receptor forms linkages with the solid support through specific or non-specific reaction with the side-chains or the backbone structure of the receptor protein. The linkage between the solid support and the receptor may also be of non-covalent nature, where electrostatic or hydrophobic forces are utilized. Apart from the biotin / avidin system other combinations of affinity ligand and corresponding receptors can be used within the scope of this invention. The following list is by no means complete and will merely serve as examples of additional combinations of affinity ligands and their receptors.

- Antibody / antigen (haptens)
  e,g. anti-DNP antibodies / targeting molecules conjugated with DNP.

- Lectins / saccharide residues
  e.g. lectin from Sambueus nigra / beta-D-gal(1-4)-D-glc

- Enzyme / enzyme inhibitors
  e.g. D-Alanin carboxypeptidase from B.subtilis or E.coli / 6-aminopenicillanic acid or p-aminobenzylpenicillin.
  e.g. Dehydrofolate reductase / aminopterin or amethopterin

- Protein / co-factors
  e.g. Intrinsic factor / vitamin B12 or cobalamin.

[0029] The adsorbent device to which the receptor is immobilized may be of various shape and chemical composition. It may for example constitute a column house filled with particulate polymers, the latter of natural origin or artificially made. The particles may be macroporous or their surface may be grafted, the latter in order to enlarge the surface area. The particles may be spherical or granulated and be based on polysaccharides, ceramic material, glass, silica,plastic, or any combination of these or alike material. A combination of these could for example be solid particles coated with a suitable polymer of natural origin or artificially made. Artificial membranes may also be used. These may be flat sheet membranes made of cellulose, polyamide , polysulfone , polypropen or other types of material which are sufficiently inert, biocompatible, non-toxic and to which the receptor could be immobilized either directly or after chemical modification of the membrane surface.Capillary membranes like the hollow fibers made from cellulose, polypropen or other materials suitable for this type of membranes may also be used.

[0030] The principle out-line of a system for processing of human plasma with the aim of removing exogenous targeting molecules in accordance with the invention is described in Fig. 1. Blood is drawn from the patient through a peristaltic pump (1) at a flow of typically 20-50 ml per min. The blood is separated into plasma and blood cells in a standard blood separation device (2), either through centrifugation or by the use of a plasma filter. Heparin and/or citrate may be added to the blood prior to the plasma separation in order to prevent blood coagulation and reduce complement activation.

[0031] Prior to entering the adsorbent device, the plasma flow will be monitored with respect to pressure and air bubbles. The latter will be removed in a standard air-trap. An optional safety filter device (6) may be used to remove any debris or particles coming out from the adsorbent device. The plasma will finally mix with the patients own blood-cells

and the blood will pass a second air-trap (4) and the pressure will be monitored before the blood is returned to the patient. A similar extracorporeal plasma adsorption system for removal of immune complexes has been described (Wallmark,A et al., Artificial Organ 8, 1984, 72).
The procedure is greatly simplified if whole blood rather than plasma is processed. The princple out-line of such a system is shown in Fig 2. Removal of specific antibodies in a continous extracorporeal whole blood system has previously been described (Nilsson , I. M et al., Plasma Ther. Transfus. Technol. 5, 1984, 127).

[0032] The following experiments are far from optimized, and should merely serve as an illustation of the use of the invention, and are not limitative of the remainder of the disclosure in any way whatsoever.

EXPERIMENTAL

Material and Methods

1. The animal model.

[0033] Nude rats with thymic aplasia has become generally accepted for testing of monoclonal antibodies for immunoscintigraphy and immunotherapy. With the possibility of implanting human tumour material in these rats, experimental animals are obtained which express human tumour antigens, in a defined place. We utilized nude rats (Rowett RNu/RNu strain) transplanted with tumour cells obtained from a tumour biopsy from a patient with melanoma metastases. The monoclonal antibody was the 96.5 (mouse IgG2a) specific for p97, a cell surface glycoprotein with the molecular weight of 97 000 present on 60 - 80 % of human melanoma. The tumour model has been described in detail (Ingvar.C.et al.. Nucl. Med 30, 1989, 1224).

2. Conjugation and labelling of monoclonal antibodies.

[0034] The monoclonal antibody 96.5 (330 µg) was labeled with 37 MBq iodine- 125 (^{125}I), using the Chloramine-T method. By elution on a Sephadex® G25 column (Pharmacia PD10) the fraction containing the labelled protein was collected and used for the conjugation. The labelling efficiency of the ^{125}I 96.5 was around 70 %. The radiolabelled monoclonal antibody was conjugated with biotin by mixing 500 µg of antibody with 41 µg of N-Hydroxysuccinimidobiotin (NHS-biotin) in 0.1 M $NaHCO_3$, 0.15M NaCl with 10% DMSO. The mixture was incubated for 1 h at room temperature, followed by overnight incubation at 4 C. The ^{125}I-McAb-biotin conjugate was separated from free biotin-reagent by gel-filtration on a Sephadex® G25 column, equilibrated with PBS (10 mM Sodium phosphate, 0.15 M NaCl, pH 7.3). The conjugate was stored at 4° C until used.

3. Radioimmunoscintigraphy with extracorporeal immunoadsorption of plasma.

[0035] Nude rats (Rowert RNu/RNu strain), 2-3 months of age, with a weight of 210±25 g were used. The rats were transplanted with tumour cells, established from a human melanoma metastase, on each thigh: intramuscularly (left) and subcutaneously (right). The immunoconjugate was injected 1-2 weeks after tumour inoculation when the tumour was just palpable. Four to seven days before injection of immunoconjugate, the rats to be treated with extracorporeal immunoadsorption have been catetherized using the carotid and the jugular blood vessels. 24 hours after injection of 50 µg conjugate (3 MBq), the rats were treated with extracorporeal immunoadsorption. Blood was pumped continuously through a hollow-fiber plasmafilter at a rate of 1.5 ml/min and plasma was separated and passed through an adsorbent column at a flow rate of 0.2 ml/min. The column contained 1.2 ml of avidin-Sepharose®, highly specific for adsorption of the biotin-conjugate. Approximately three plasma volumes were treated during a 3 h period. The animals were imaged with a scintillation camera (General Electric T400) before, and directly after the extracorporeal treatment. The rats were killed with an overdose of ether and various organs (see table 1 for list of organs) were removed. Each tissue sample was weighed and measured in an automatic NaI(Tl) gamma counter for radioactivity content. The specific tissue uptake was expressed as % of injected dose per gram of tissue (%/g) and as an uptake ratio (%/g tumour)/(%/g tissue). Control rats were neither catetherized nor treated with extracorporeal immunoadsorption.

Results

[0036] During extracorporeal immunoadsorption of these rats, 90-95 % of the radioactivity in the blood were removed, corresponding to about 40-50 % of the total activity in the animals. The immunoscintigrams are presented in figure 3, and the results from the measurements of tissue specific activities in table 1. These results are well in agreement with theoretical evaluations based on simulated extracorporeal immunoadsorption using a computerized mathematical model (Norrgren K. et al., Antibody Immunoconjugates, and Radiopharmaceuticals, in press; copy enclosed).

3. Radioimmunoscintigraphy with extracorporeal immunoadsorption of whole blood.

[0037] Euthymic rats (Wistar/Furth strain), 2-3 months of age, with a weight of 210±25 g were used. Four to seven days before injection of immunoconjugate, the rats were catetherized using the carotid and the jugular blood vessels. 24 hours after injection of 50 µg conjugate (5 MBq), the rats were subjected to extracorporeal immunoadsorption. Blood was pumped continuously through an adsorbent column at a flow rate of 0.2 ml/min. The column (1.5 ml) contained avidin covalently linked to Sepharose® 6 MB macrobeads. The macrobeads allow direct adsorption of whole blood. Approximately three blood volumes were treated during a 3 h period. The animals were analyzed with a scintillation camera (General Electric T400) before, and directly after the extracorporeal treatment. The rats were killed with an overdose of ether and various organs (see table 2 for list of organs) were removed. Each tissue sample was weighed and measured in an automatic NaI(Tl) gamma counter for radioactivity content. The specific tissue uptake was expressed as % of injected dose per gram of tissue (%/g). Control rats were neither catetherized nor treated with extracorporeal immunoadsorption.

Results

[0038] During extracorporeal immunoadsorption of the rats, 90-95 % of the radioactivity in the blood were removed, corresponding to about 40-50 % of the total body activity. The immunoscintigrams are presented in figure 3, and the results from the measurements of tissue activities in table 2. The extracorporeal immunoadsorption of whole blood was of the same efficiency as immunoadsorption of plasma, but is technically easier to perform.

Table 1

Tissue uptake and binding ratio with and without extracorporeal immunoadsorption.						
	Control Rats		Rats treated with ECIA			
Tissue	%/gram	ratio	%/gram	ratio	%depletion	improvement
Tumour	0.48 +/-0.03	1.00	0.24 +/-0.11	1.00	50.1	1.00
plasma	2.23 +/-0.37	0.22 +/-0.06	0.15 +/-0.03	1.34 +/-0.64	93.1	5.99
Lymph nodes	0.38 +/-0.07	1.30 +/-0.32	0.18 +/-0.08	1.29 +/-0.27	51.9	0.99
muscules	0.17 +/-0.09	3.35 +/-1.45	0.10 +/-0.02	2.50 +/-0.89	43.7	0.75
kidney	0.35 +/-0.05	1.39 +/-0.25	0.07 +/-0.02	3.86 +/-2.21	80.8	2.78
liver	0.32 +/-0.05	1.52 +/-0.19	0.05 +/-0.02	5.24 +/-3.69	83.9	3.45
spleen	0.23 +/-0.03	2.17 +/-0.33	0.04 +/-0.006	6.95 +/-4.35	83.5	3.20
heart	0.22 +/-0.08	2.45 +/-1.03	0.07 +/-0.01	3.37 +/-1.34	67.9	1.37
lung	0.52 +/-0.07	0.95 +/-0.15	0.14 +/-0.07	1.70 +/-0.43	72.1	1.80
bone marrow	0.34 +/-0.05	1.44 +/-0.24	0.05 +/-0.01	5.47 +/-3.02	86.4	3.79
stomach	0.22 +/-0.003	2.05 +/-0.08	0.17 +/-0.09	1.62 +/-1.52	24.3	0.79

%/gram: % of the total body activity measured per gram of the respective tissue. (mean +/- S.D.)
Ratio: (%/gram tumour)/(%/gram normal tissue) (mean+/- S.D.)
ECIA : extracorporeal immunoadsorption.
% depletion : 100*((%/gram without ECIA- %/gram with ECIA)/(%/gram without ECIA))
Improvement : ratio with ECIA/ratio without ECIA.

Table 2

Tissue uptake and binding ratio with and without extracorporeal immunoadsorption of whole blood.			
Tissue	Control Rats %/gram	Rats treated with ECIA %/gram	% depletion
plasma	3.22	0.35	89.1
lymph nodes	0.31	0.25	19.4
muscules	0.11	0.08	27.3
kidney	0.56	0.11	80.4
liver	0.42	0.10	76.2
spleen	0.24	0.09	62.5
heart	0.35	0.13	62.8
lung	0.60	0.24	60.0
bone marrow	0.45	0.13	71.1
%/gram: % of the total body activity measured per gram of the respective tissue. (mean) ECIA : extracorporeal immunoadsorption of whole blood. % depletion : 100*((%/gram without ECIA- %/gram with ECIA)/(%/gram without ECIA))			

Claims

1. Kit for extracorporeally eliminating or at least reducing the concentration of a non-tissue-bound target specific therapeutic or diagnostic agent, which is selective for certain tissues or cells and has been introduced to a vertebrate host and kept therein for a certain time in order to be concentrated to the target tissues or cells by being attached thereto, in the plasma or whole blood of the vertebrate host, said kit comprising a target specific therapeutic or diagnostic agent, means for extracorporeal circulation of whole blood or plasma from the vertebrate host, an optional plasma separation device for separation of plasma from whole blood, an extracorporeal adsorption device, and a means for return of whole blood or plasma without or with low concentration of non-tissue-bound target specific therapeutic or diagnostic agent to the vertebrate host, **characterised** in that the adsorption device comprises immobilised receptors specific towards an affinity ligand conjugated with the non-tissue-bound target specific therapeutic or diagnostic agent for binding of said conjugate in the adsorption device, wherein the receptor/affinity ligand combination is an enzyme/enzyme inhibitor or vice versa, or a protein/co-factor or vice versa, with the proviso that the protein is not naturally occurring avidin and that the co-factor is not naturally occurring biotin at the same time.

2. Kit according to claim 1, **characterised** in that the protein is a fragment or a derivative of avidin, or another biotin-binding receptor, and the co-factor is biotin or derivatives thereof.

3. Kit according to claim 1, **characterised** in that the protein is an intrinsic factor and that the co-factor is vitamin B12 or cobalamin.

4. Kit according to claims 1 and 2, **characterised** in that the biotin-binding receptor is streptavidin, or a derivative or a fragment thereof.

5. Kit according to claims 2 and 4, **characterised** in that the biotin derivative is 2-aminobiotin, desthiobiotin or diaminobiotin.

6. Kit according to claim 1, **characterised** in that the enzyme is conjugated with the target specific therapeutic or diagnostic agent and the immobilised receptor constitutes the enzyme inhibitor, and wherein said enzyme is capable of converting pro-drugs to active drugs, preferably those possessing tumour killing or tumour regressive effects.

7. Kit according to claim 6, **characterised** in that the enzyme/enzyme inhibitor combination is D-alanine carboxy peptidase from B. subtilis or E. coli/6-amino penicillanic acid or p-aminobenzyl penicillin, or dehydropholate reductase/amino pterin or amethospterin.

8. Kit according to any of the previous claims, **characterised** in that the affinity ligand is covalently linked to the target specific therapeutic or diagnostic agent.

9. Kit according to any of the previous claims, **characterised** in that the target specific therapeutic or diagnostic agent conjugated to the affinity ligand carries a radioisotope, a cytotoxic agent, or an agent which can convert a pro-drug to an active drug.

10. Kit according to any of the previous claims, **characterised** in that the affinity ligand is radiolabeled.

11. Kit according to claim 10, **characterised** in that the receptor/affinity ligand combination is biotin/avidin.

12. Kit according to any of claims 1 - 8, **characterised** in that the affinity ligand is directly attached to a cytotoxic agent or an agent which can convert a pro-drug to an active drug and where either of these latter are further attached to the target specific therapeutic or diagnostic agent.

13. Kit according to claim 12, **characterised** in that the receptor/affinity ligand combination is biotin/avidin.

14. Kit according to any of claims 1 - 10 and 12, **characterised** in that the target specific therapeutic or diagnostic agent conjugated to the affinity ligand is an antibody, fragments thereof, peptides or chemically synthesised peptide-derivatives based on the specificity of the antigen-binding region of one of or several target specific monoclonal antibodies selected from the group consisting of chimeric antibodies, single chain antibodies and alike antibody derivatives.

15. Kit according to any of claims 1 - 10 and 12, **characterised** in that the target specific therapeutic or diagnostic agent is a protein, and that the affinity ligand constitute an artificially introduced amino acid sequence of the protein sequence of the target specific therapeutic or diagnostic agent, wherein said artificially introduced amino acid sequence has been induced by genetic engineering into the target specific therapeutic or diagnostic agent using mutation, DNA-hybridisation or other fusion techniques.

16. Kit according to claims 1 - 8, **characterised** in that a cytotoxic agent or an agent which can convert a pro-drug to an active drug is bound to the affinity ligand.

17. Kit according to claim 16, **characterised** in that the receptor/affinity ligand combination is biotin/avidin.

18. Kit according to any of the previous claims, **characterised** in that the immobilised receptors are immobilised to polymeric particles in a column house.

19. Kit according to claim 18, **characterised** in that the immobilised receptor is immobilised to polymeric particles based on polysaccharides, ceramic material, glass, silica or plastic, or combinations thereof.

20. Kit according to claims 18 - 19, **characterised** in that the immobilised receptors are immobilised to artificial membranes made of cellulose, polyamide, polysulfone or polypropen, and to which the receptor could be immobilised either directly to the membrane or after chemical modification of the membrane surface including a capillary membrane.

21. Kit according to claim 20, **characterised** in that the capillary membrane is a hollow-fibre made from cellulose or polypropen.

Patentansprüche

1. Ausrüstung zum extrakorporalen Entfernen oder wenigstens Reduzieren der Konzentration eines nicht gewebegebundenen, zielspezifischen therapeutischen oder diagnostischen Agens, das selektiv für bestimmte Gewebe oder Zellen, ist und in einen Wirbeltier-Wirt eingeführt und dort für eine bestimmte Zeit gehalten wurde, um es in den Zielgeweben oder -zellen zu konzentrieren, indem es daran angeheftet wird, im Plasma oder Gesamtblut des Wir-

beltier-Wirts, wobei die besagte Ausrüstung ein zielspezifisches therapeutisches oder diagnostisches Agens, Mittel zur extrakorporalen Zirkulation von Gesamtblut oder Plasma des Wirbeltier-Wirts, eine optionale Vorrichtung zur Trennung von Plasma von Gesamtblut, eine extrakorporale Adsorptions-Vorrichtung sowie ein Mittel zur Rückführung von Gesamtblut oder Plasma ohne oder mit niedriger Konzentration an nicht gewebegebundenem, zielspezifischem therapeutischem oder diagnostischem Agens in den Wirbeltier-Wirt umfaßt, dadurch gekennzeichnet, daß die Adsorptions-Vorrichtung immobilisierte Rezeptoren umfaßt, die spezifisch sind gegenüber einem Affinitäts-Liganden, der mit dem nicht gewebegebundenen, zielspezifischen therapeutischen oder diagnostischen Agens konjugiert ist, um das besagte Konjugat in der Adsorptions-Vorrichtung zu binden, wobei die Kombination Rezeptor/Affinitätsligand ein Enzym/Enzyminhibitor oder umgekehrt, oder ein Protein/Kofaktor oder umgekehrt ist, unter der Bedingung, daß das Protein nicht natürlich vorkommendes Avidin und daß nicht zugleich der Kofaktor natürlich vorkommendes Biotin ist.

2. Ausrüstung nach Anspruch 1, dadurch gekennzeichnet, daß das Protein ein Fragment oder ein Derivat von Avidin oder einem anderen Biotin-bindenden Rezeptor ist, und daß der Kofaktor Biotin oder ein Derivat davon ist.

3. Ausrüstung nach Anspruch 1, dadurch gekennzeichnet, daß das Protein ein intrinsischer Faktor ist, und daß der Kofaktor Vitamin B12 oder Cobalamin ist.

4. Ausrüstung gemäß den Ansprüchen 1 und 2, dadurch gekennzeichnet, daß der Biotin-bindende Rezeptor Streptavidin oder ein Derivat oder ein Fragment davon ist.

5. Ausrüstung gemäß den Ansprüchen 2 und 4, dadurch gekennzeichnet, daß das Biotin-Derivat 2-Aminobiotin, Desthiobiotin oder Diaminobiotin ist.

6. Ausrüstung nach Anspruch 1, dadurch gekennzeichnet, daß das Enzym mit dem zielspezifischen therapeutischen oder diagnostischen Agens konjugiert ist und der immobilisierte Rezeptor den Enzyminhibitor darstellt, wobei das Enzym in der Lage ist, Wirkstoffvorläufer in aktive Wirkstoffe umzuwandeln, bevorzugt solche mit Tumor-tötenden oder Tumor-regressiven Effekten.

7. Ausrüstung nach Anspruch 6, dadurch gekennzeichnet, daß die Enzym/Enzyminhibitor-Kombination D-Alanin-Carboxypeptidase von B. subtilis oder E. coli/6-Aminopenizillansäure oder o-Aminobenzylpenizillin ist, oder Dehydrofolat-Reduktase/Aminopterin oder Amethospterin ist.

8. Ausrüstung nach einem der vorhergehenden Ansprüche, dadurch gekennzeichnet, daß der Affinitätsligand kovalent an das zielspezifische therapeutische oder diagnostische Agens gebunden ist.

9. Ausrüstung nach einem der vorhergehenden Ansprüche, dadurch gekennzeichnet, daß das mit dem Affinitätsliganden konjugierte zielspezifische therapeutische oder diagnostische Agens ein Radioisotop, ein zytotoxisches Agens, oder ein Agens enthält, das einen Wirkstoffvorläufer in einen aktiven Wirkstoff umwandeln kann.

10. Ausrüstung nach einem der vorhergehenden Ansprüche, dadurch gekennzeichnet, daß der Affinitätsligand radioaktiv markiert ist.

11. Ausrüstung nach Anspruch 10, dadurch gekennzeichnet, daß die Kombination Rezeptor/Affinitätsligand Biotin/Avidin ist.

12. Ausrüstung nach einem der Ansprüche 1-8, dadurch gekennzeichnet, daß der Affinitätsligand direkt an ein zytotoxisches Agens oder an ein Agens, das einen Wirkstoffvorläufer in einen aktiven Wirkstoff umwandeln kann, gebunden ist und wo eines der letzteren wiederum an das zielspezifische therapeutische oder diagnostische Agens gebunden ist.

13. Ausrüstung nach Anspruch 12, dadurch gekennzeichnet, daß die Kombination Rezeptor/Affinitätsligand Biotin/Avidin ist.

14. Ausrüstung nach einem der Ansprüche 1-10 und 12, dadurch gekennzeichnet, daß das zielspezifische therapeutische oder diagnostische Agens, das mit einem Affinitätsliganden konjugiert ist, ein Antikörper ist, Fragmente davon, Peptide oder chemisch synthetisierte Peptid-Derivate basierend auf der Spezifität der antigenbindenden Region von einem aus mehreren oder von mehreren zielspezifischen monoklonalen Antikörpern, die aus der

Gruppe bestehend aus chimeren Antikörpern, Einzelketten-Antikörpern und ähnlichen Antikörper-Derivaten gewählt wurde.

15. Ausrüstung nach einem der Ansprüche 1-10 und 12, dadurch gekennzeichnet, daß das zielspezifische therapeutische oder diagnostische Agens ein Protein ist und daß der Affinitätsligand eine künstlich eingeführte Aminosäuresequenz der Proteinsequenz des zielspezifischen therapeutischen oder diagnostischen Agens darstellt, worin die besagte künstlich eingeführte Aminosäuresequenz im zielspezifischen therapeutischen oder diagnostischen Agens gentechnisch mittels Mutation, DNA-Hybridisierung oder anderen Fusions-Techniken herbeigeführt wurde.

16. Ausrüstung gemäß den Ansprüchen 1-8, dadurch gekennzeichnet, daß ein zytotoxisches Agens oder ein Agens, das einen Wirkstoffvorläufer in einen aktiven Wirkstoff umwandeln kann, an den Affinitätsliganden gebunden ist.

17. Ausrüstung nach Anspruch 16, dadurch gekennzeichnet, daß die Kombination Rezeptor/Affinitätsligand Biotin/Avidin ist.

18. Ausrüstung nach einem der vorhergehenden Ansprüche, dadurch gekennzeichnet, daß die immobilisierten Rezeptoren an polymeren Teilchen in einem Säulengehäuse immobilisiert sind.

19. Ausrüstung nach Anspruch 18, dadurch gekennzeichnet, daß der immobilisierte Rezeptor an polymeren Teilchen basierend auf Polysacchariden, keramischen Materialien, Glas, Kieselgel oder Plastik oder aus Kombinationen hiervon immobilisiert ist.

20. Ausrüstung gemäß den Ansprüchen 18-19, dadurch gekennzeichnet, daß die immobilisierten Rezeptoren an künstlichen Membranen, hergestellt aus Zellulose, Polyamid, Polysulfon oder Polypropen, immobilisiert sind und an denen der Rezeptor entweder direkt an der Membran oder nach chemischer Modifikation der Membranoberfläche immobilisiert werden konnte, einschließlich einer Kapillarmembran.

21. Ausrüstung nach Anspruch 20, dadurch gekennzeichnet, daß die Kapillarmembran eine Hohlfaser aus Zellulose oder Polypropen ist.

Revendications

1. Kit pour l'élimination ou au moins la réduction extracorporelle de la concentration d'un agent thérapeutique ou diagnostique spécifique de cibles non lié à un tissu, qui est sélectif pour certains tissus ou certaines cellules et qui a été introduit dans un hôte vertébré et maintenu dans celui-ci pendant un certain temps pour être concentré dans les tissus cibles ou les cellules cibles en étant fixé à ceux-ci, dans le plasma ou le sang total de l'hôte vertébré, ledit kit comprenant un agent thérapeutique ou diagnostique spécifique de cibles, des moyens pour la circulation extracorporelle du sang total ou du plasma depuis l'hôte vertébré, et un dispositif facultatif de séparation de plasma pour séparer le plasma du sang total, un dispositif d'adsorption extracorporelle et un moyen pour renvoyer le sang total ou le plasma sans ou avec une faible concentration d'agent thérapeutique ou diagnostique spécifique de cibles non lié à un tissu à l'hôte vertébré, caractérisé en ce que le dispositif d'adsorption comprend des récepteurs immobilisés spécifiques d'un ligand d'affinité conjugué avec l'agent thérapeutique ou diagnostique spécifique de cibles non lié à un tissu pour fixer ledit conjugué dans le dispositif d'adsorption, où la combinaison récepteur/ligand d'affinité est une enzyme/inhibiteur d'enzyme ou vice versa, ou une protéine/cofacteur ou vice versa, à condition que la protéine ne soit pas l'avidine naturelle et que le cofacteur ne soit pas la biotine naturelle en même temps.

2. Kit selon la revendication 1, caractérisé en ce que la protéine est un fragment ou un dérivé de l'avidine ou un autre récepteur fixant la biotine, et le cofacteur est la biotine ou des dérivés de celle-ci.

3. Kit selon la revendication 1, caractérisé en ce que la protéine est un facteur intrinsèque et en ce que le cofacteur est la vitamine B12 ou la cobalamine.

4. Kit selon les revendications 1 et 2, caractérisé en ce que le récepteur de fixation de la biotine est la streptavidine ou un dérivé ou fragment de celle-ci.

5. Kit selon les revendications 2 et 4, caractérisé en ce que le dérivé de la biotine est la 2-aminobiotine, la desthiobiotine ou la diaminobiotine.

6. Kit selon la revendication 1, caractérisé en ce que l'enzyme est conjuguée avec l'agent thérapeutique ou diagnostique spécifique de cibles et le récepteur immobilisé constitue l'inhibiteur d'enzyme, et où ladite enzyme est capable de convertir des précurseurs de médicaments en médicaments actifs, de préférence ceux possédant des effets de destruction de tumeurs ou de régression de tumeurs.

7. Kit selon la revendication 6, caractérisé en ce que la combinaison enzyme/inhibiteur d'enzyme est la D-alanine carboxypeptidase de B. subtilis ou de E. coli/acide 6-aminopénicillanique ou p-aminobenzylpénicilline, ou la déshydrofolate réductase/aminoptérine ou améthoptérine.

8. Kit selon l'une quelconque des revendications précédentes, caractérisé en ce que le ligand d'affinité est lié de manière covalente à l'agent thérapeutique ou diagnostique spécifique de cibles.

9. Kit selon l'une quelconque des revendications précédentes, caractérisé en ce que l'agent thérapeutique ou diagnostique spécifique de cibles conjugué au ligand d'affinité porte un radioisotope, un agent cytotoxique ou un agent qui peut convertir un précurseur de médicament en un médicament actif.

10. Kit selon l'une quelconque des revendications précédentes, caractérisé en ce que le ligand d'affinité est radiomarqué.

11. Kit selon la revendication 10, caractérisé en ce que la combinaison récepteur/ligand d'affinité est la biotine/avidine.

12. Kit selon l'une quelconque des revendications 1 à 8, caractérisé en ce que le ligand d'affinité est fixé directement à un agent cytotoxique ou un agent qui peut convertir un précurseur de médicament en un médicament actif et où l'un quelconque de ces derniers est fixé en outre à l'agent thérapeutique ou diagnostique spécifique de cibles.

13. Kit selon la revendication 12, caractérisé en ce que la combinaison récepteur/ligand d'affinité est la biotine/avidine.

14. Kit selon l'une quelconque des revendications 1 à 10 et 12, caractérisé en ce que l'agent thérapeutique ou diagnostique spécifique de cibles conjugué au ligand d'affinité est un anticorps, des fragments de celui-ci, des peptides ou des dérivés peptidiques synthétisés chimiquement basés sur la spécificité de la région de fixation d'antigènes d'un ou plusieurs anticorps monoclonaux spécifiques de cibles choisis dans le groupe consistant en les anticorps chimères, les anticorps à une seule chaîne elles dérivés d'anticorps analogues.

15. Kit selon l'une quelconque des revendications 1-10 et 12, caractérisé en ce que l'agent thérapeutique ou diagnostique spécifique de cibles est une protéine et en ce que le ligand d'affinité constitue une séquence d'acides aminés introduite artificiellement de la séquence protéique de l'agent thérapeutique ou diagnostique spécifique de cibles, où ladite séquence d'acides aminés introduite artificiellement a été induite par génie génétique dans l'agent thérapeutique ou diagnostique spécifique de cibles par mutation, hybridation d'ADN ou d'autres techniques de fusion.

16. Kit selon les revendications 1-8, caractérisé en ce qu'un agent cytotoxique ou un agent qui peut convertir un précurseur de médicament en un médicament actif est lié au ligand d'affinité.

17. Kit selon la revendication 16, caractérisé en ce que la combinaison récepteur/ligand d'affinité est la biotine/avidine.

18. Kit selon l'une quelconque des revendications précédentes, caractérisé en ce que les récepteurs immobilisés sont immobilisés sur des particules polymères dans une enceinte de colonne.

19. Kit selon la revendication 18, caractérisé en ce que le récepteur immobilisé est immobilisé sur des particules polymères à base de polysaccharides, de matériau céramique, de verre, de silice ou de plastique, ou de combinaisons de ceux-ci.

20. Kit selon les revendications 18-19, caractérisé en ce que les récepteurs immobilisés sont immobilisés sur des membranes artificielles constituées par de la cellulose, du polyamide, de la polysulfone ou du polypropène, et sur lesquelles le récepteur a pu être immobilisé sur la membrane directement ou après modification chimique de la surface de la membrane y compris une membrane capillaire.

21. Kit selon la revendication 20, caractérisé en ce que la membrane capillaire est une fibre creuse constituée par de la cellulose ou du polypropène.

FIG 1

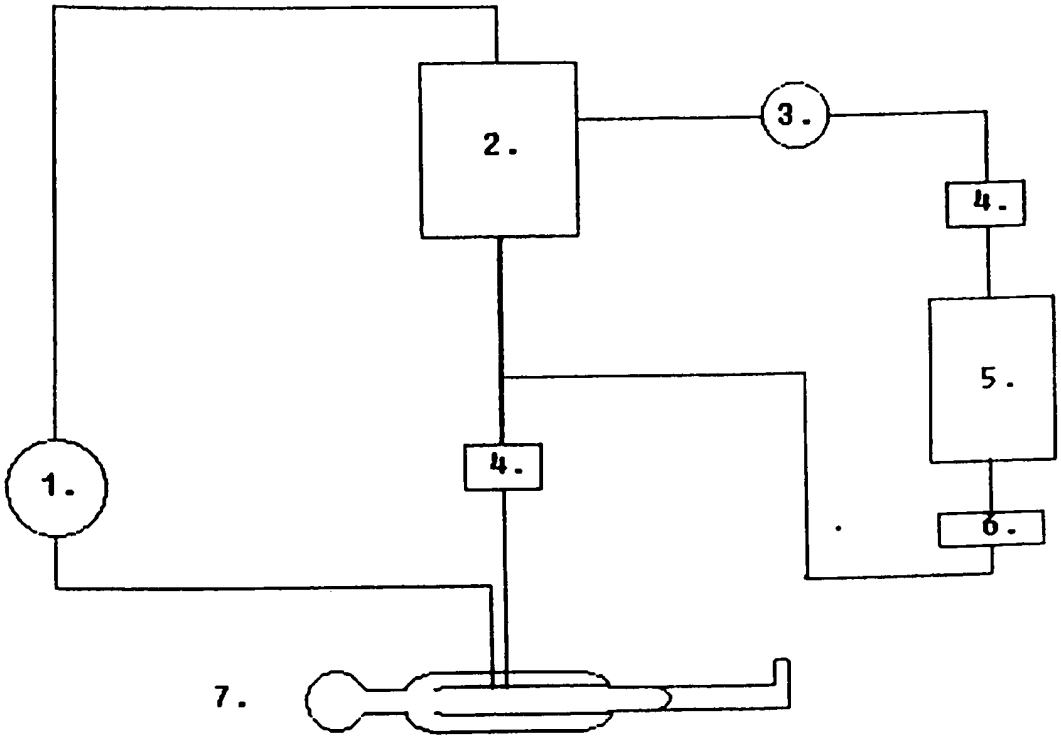

FIG 2

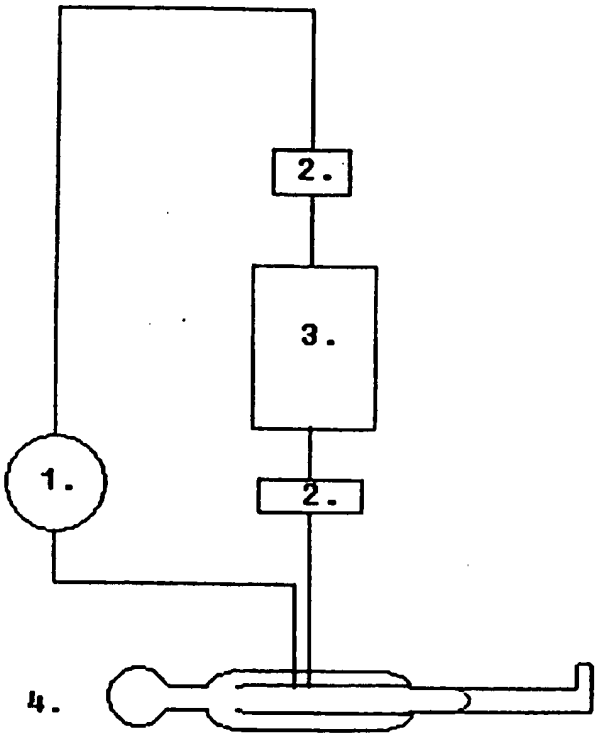

FIG 3A

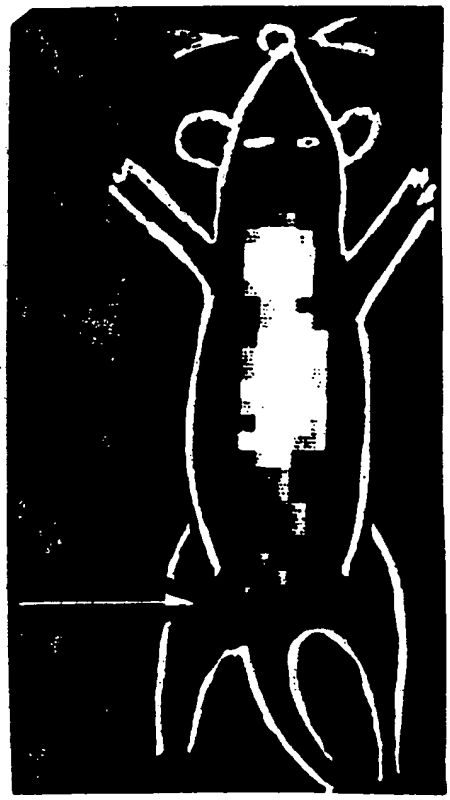

FIG 3B